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Calling Police to Primary Care. Does Normalisation Process Theory help understand the (non)implementation of a Domestic Abuse Notification Scheme.

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Abstract

Normalisation Process Theory (NPT), used nationally and internationally to explore the success of implementation particularly within health services research, is used for the first time in this paper to understand a case of spectacular implementation failure within police work. The policy in question was an intervention designed to notify GPs when police attend incidents where women are assessed at high risk of future DA. Designed to improve inter-agency communication and improve GP responses to women, it took place amidst radical organisational change for the police force involved.

Using qualitative methods, we assessed the journey of the intervention into practice using NPT which is concerned with addressing *if, how* and *why* new practices become 'normalised' within professionals' repertoires.

We found that the intervention to be invisible. Dwarfed by its organisational context, made institutionally hard-to-read by a lack of formal protocols, and given restricted view to police officers, it was ultimately compromised by a failure to instigate systems of organisational learning.

NPT proved useful in understanding mechanisms that, within the context of change, led to minimal implementation of the intervention: poor operational alignment with existing practice; faulty communication of purpose; and, inattention to discretionary spaces around implementation.

The theory's utility across policy contexts could be strengthened by better foregrounding the centrality of organisational, financial and political context and how they structure each stage of implementation; and by attending more to spaces for discretionary practice. Nonetheless, in combination with other implementation concepts, the theory has potential in understanding implementation in contexts beyond health.

Key Words: Domestic Abuse, Normalisation Process Theory, Implementation, Police,

Introduction

Public service responses to domestic abuse (DA) across the UK, and internationally, are increasingly marked by multi-agency collaboration aimed at better response to abuse. Albeit imperfect, improved communication pathways and systematised collaboration within and between public and third sector organisations have contributed to more survivor/victim-centred approaches. In keeping with this goal of joint working, a pilot was developed in 2012 by Strathclyde Police force (Scotland), whereby officers offered to notify victims' GPs of abuse. The scheme required signed consent from victims whose GPs would be notified of the abuse by letter. Around the same time as the pilot, referred to herein as Police to Primary Care (P2PC), there was radical organisational change to policing in Scotland culminating in the merger of its eight territorial police forces into one (Police Scotland). Both context (organisational mergers and restructuring) and problem (improving interagency communication aimed at safe-guarding victims of abuse) are national as well as international concerns beyond the Scottish case.

Against this backdrop we evaluated P2PC. Here we focus on its implementation within Police Scotland through the analytical lens of Normalisation Process Theory (NPT). NPT was first developed and deployed to study implementation within health services research and seeks to delineate *how* and *why* new practices become 'normalised' within professional repertoires – it has become a key tool in academic endeavours to investigate implementation in health across a range of national contexts. In using concepts from NPT, we identify if and how the work necessitated by P2PC became embedded within existing practice for Police Scotland and, in so doing, test the utility of NPT in implementation research.

This paper identifies mechanisms that undermined effective implementation within Police Scotland, an organisation otherwise applauded for its leadership in tackling DA (Scottish Government, 2014). Within the context of organisational change, these mechanisms included the alignment of P2PC with existing practice, the strategic signalling of the intervention's purpose, and the creation of discretionary spaces in frontline police work. The paper discusses these in relation to NPT and, to our knowledge, is the first to use NPT within the context of contemporary policing. First, we describe P2PC including what has been its (very) partial journey into practice; second, we provide a brief background to NPT; third, we describe the methods used in the current study; and finally, we set out findings concerning P2PC implementation and of the utility of NPT as an implementation frame beyond the health context.

Background to P2PC

DA damages the health of adults (predominantly women) and of children exposed to the abuse of a parent (Stanley 2011). Those who suffer DA are at greater risk of physical injury,

mental health problems, suicide and death from homicide. Further, they are less likely to be employed, in greater need of emergency and social housing, make higher than average use of the criminal justice system and, where they have children, more likely to be in contact with social services (Walby, 2004). In total, the cost to the public purse of DA in England and Wales is estimated to be at least £16 billion annually (Walby, 2009).

Tackling DA is a priority for Scottish and UK governments (HMIC, 2014; Home Office, 2012; Scottish Government, 2010) as well as globally (WHO, 2013). A key strand of current policy seeks to mitigate its impact by promoting multi-agency approaches to increase the level of support available to its victims. Across the UK, recent years have seen significant developments, including the creation of DA Courts, specialist advocacy services and the establishment of Multi-Agency Risk Assessment Conferences designed to prioritise the safety of victims. Police Scotland's role in providing leadership for this agenda has been described as 'exemplary' (Scottish Government, 2014).

Given most victims' interactions with health services, it might be assumed that, in the UK, the NHS has a pivotal role in addressing DA. Yet often abuse is undetected by health professionals (Feder et al, 2006). Lack of training, uncertainty about appropriate responses to disclosure and pressure of time are commonly cited by GPs as impediments to raising the issue. Additionally, GPs seldom engage in multi-agency initiatives and may have little knowledge of the community resources available (Szilassy et al, 2015).

Since 2008, national programmes in the UK have sought to improve the identification and management of DA through the introduction of routine enquiry in a variety of health services. Within primary care, interventions and policies have been developed to increase disclosure and establish response pathways. One of these, the on-going Identification and Referral to Improve Safety (IRIS) programme (Feder et al, 2011), has informed the Royal College of General Practice (RCGP, 2012), NICE (NICE, 2016) and WHO (WHO, 2013) guidelines, and has been piloted in Scotland.

In 2012, Strathclyde Police proposed a pilot whereby, with the victim's consent, they would notify the relevant GP of a DA incident by letter. Such a scheme has not, to our knowledge been formally tested in the UK nor in other similar jurisdictions such as Australia and New Zealand (Heggarty, personal communication). The scheme, supported by women's advocacy agencies, was piloted across the five divisions of Strathclyde Police, referred to since the inception of Police Scotland in 2013, as Legacy Strathclyde. Given the scale of abuse in Scotland (there were 58,104 reported incidents in 2015-16, Scottish Government, 2016) – it was decided that the scheme would only apply to cases where the victim was considered to be at high risk of serious harm. The ambition of the pilot was to enhance communication across agencies and, further, (implicitly) to encourage GPs to raise the issue with the patient and inform their assessment of health needs.

The information flow was directly from the police to the relevant GP. Prior to its introduction the primary care leads in each of 3 health boards covering Strathclyde were assured that letters would only be sent once the victim had consented to the notification; they were not required to share the information further, or feedback to the police. Any sharing of health data would only be done in line with established protocol and the NHS Code of Practice, satisfying Caldicott principles that it would be proportionate, relevant and limited to the minimum amount of information (UK Council of Caldicott Guardians 2012).

As with any new intervention, a key precursor to making a difference to GP responses was that it should be effectively implemented. Our chosen framework for assessing implementation was May and Finch's Normalisation Process Theory (2009); we explain and describe our choice of frame before setting out how we studied the implementation of P2PC.

Background to Normalisation Process Theory and its pertinence to this case

As argued by Cairney (2012), the study of policy implementation is necessitated by the regular departure of practice from policy (not least within police work – Kirby, 2013). Theories of such implementation 'gaps' have focused predominantly on: top-down approaches that seek to understand what has prevented policy (a fully formed entity) being practiced in its planned fashion: or, bottom-up approaches that contest that policy is made predominantly by high-level decision-makers, arguing instead that it is made in encounters between service users and professionals working on the ground (typified by the study of street level bureaucrats as per Lipsky (1980) and subsequent generations of street level investigators – see Hupe and Hill, 2015).

The apparent simplicity of P2PC (as described above) with its relatively short implementation chain, as well as the researchers' broader ontological sympathy with street level theorists' concerns with frontline workers making not just enacting policy, the current study started out with an expectation that it would find variations in practice that would best be explained by officers finding discretionary spaces.

Research team's expectations were confounded by early evidence that the intervention rather than exhibiting nuanced variations in implementation had instead crashed and burned. In seeking a frame more suited to understanding blanket implementation failure as well as discretionary practice we moved to adopt the frame of Normalisation Process Theory (NPT), developed to explain *how* new practices (sometimes generated through policy) make their journey into work routines. The theory emphasises the emergent properties of organisations and systems of professional routines which, within broader structures, operate as the context for new practices and the work that is done by professionals as they individually and collectively encounter, adopt, and absorb (or indeed resist) new work that is to be inserted into existing daily routines. From this, and consistent with, street-level explorations, it follows that implementation is a process rather than a

finished product. Further, what is being implemented is not a single task but 'an ensemble – of material and cognitive practices' (May, 2013:p.2). The 'new', they emphasise, need not be innovative, it may be 'conservative and focus on standardisation and regulation of practices' (ibid, p.537). As we shall see, the question of the 'newness' of P2PC raised an interesting paradox for its resilience.

According to May and Finch, NPT has four main constructs (each with sub-constructs – drawn out, where relevant, in the following analysis). The first is *coherence,* referring to the meaning ascribed individually and collectively to a new set of practices. The second is *cognitive participation* and denotes commitment to engage with the new. Construct three is referred to as *collective action*, intended to address how it is that the work does or indeed does not get done. Finally, *reflexive monitoring*, relates to the processes through which practitioners decide whether new approaches are beneficial and, ultimately, to the normalisation of new practices.

As so far introduced the *meaning* of the constructs is rather opaque. However, when posed as a series of questions – prompts which allow a researcher to unpack the constructs in relation to their intended object of study – their value becomes much more obvious. For example, regarding *coherence*, we might ask: Can the new be differentiated from what exists already? Are individuals and groups of people able to do the sense-making that allows them to build a shared understanding of the aims and benefits of new practices and of what they, as practitioners, need to do to enact these? In terms of *cognitive participation*: Do key individuals appropriately initiate strategies to begin the process of implementation? Do they engage those who will be affected by new routines? Is engagement of key practitioners legitimated by managers and co-workers? Are the procedures necessary for implementation in place? May and Finch parse this unwieldy construct as: how do participants come to engage with a practice? To understand *collective action* we might ask: how does the work get done? Finally, the normalisation of new practices depends on *reflexive monitoring:* In what ways do managers and practitioners decide that new approaches are of benefit?

Although May and Finch did not single out health for the deployment of NPT it has been researched predominantly within this setting (McEvoy et al, 2014; Bamford et al, 2010; Murray et al, 2011), including in relation to DA (Hooker et al., 2015). Over a short space of time, NPT has become a well-established analytical tool in health research that is concerned with the contingencies of implementation. And, although McEvoy et al (2014) in their review of studies using NPT concluded that there was distinct danger in donning NPT like a "'conceptual straitjacket'" (2014, p11), its broad tenets, nonetheless, have been found to have explanatory value.

Methods

In the study on which this paper draws, we used a combination of qualitative methods and monitoring data to answer two research questions: (1) how/to what extent was P2PC implemented? And, (2) how was P2PC perceived by key participant groups (police, general practitioners and women experiencing abuse)? A description of the methods deployed across the study are reported elsewhere (Mackenzie et al., 2016); in this paper we summarise the methods pertinent to the examination of P2PC's implementation within Police Scotland.

Methods and sampling

To assess P2PC implementation (research question 1), we mapped the pathway from incident to GP notification letter being sent, and assessed adherence to this pathway from April, 2013 to March, 2014 through a critical analysis of routine data. This entailed attempting a comparison of anonymised police data on incidents reported as high risk with those: reported as such to specialist Domestic Abuse Investigation Units (DAIUs)s; those where DAIUs contacted the victim for consent to notification; and with onward notification. DAIUs were asked to complete a date template for each month of the selected period.

Our second aim was to understand implementation from a police perspective (research question 2). This was met using mixed qualitative methods since our interest was in generating data concerning perceptions of the intervention and reflections of its coherence and plausibility in context. We developed semi-structured interview schedules deployed in individual or focus group settings. We undertook focus groups with staff in the five area DAIUs within Legacy Strathclyde covered by the pilot (a total of 13 participants). Focus groups were utilised because Unit officers operate as a team and we wanted to understand implementation at the team level. These were followed by interviews with police officers purposively selected within each division to give optimum variation in relation to, gender, geographical location and knowledge of the pilot (N=22) with the DACU acting as gatekeeper. Interviews were selected because frontline officers' engagement with P2PC was at an individual level – as part of routine practice rather than as part of a specialist unit. The majority of these interviews were with frontline response and community police officers (N=20). The remaining two involved officers working within DAIUs who had not participated in the focus groups. In total we interviewed 35 police officers.

Data collection and analysis

The interview schedules were generated to address questions concerning implementation; all interviews were transcribed in full. Our analytical strategy for interrogating the data was two-fold: first, we explored data in relation to the context for P2PC and the mechanisms impacting on implementation within that context; second, we created themes relating to

our operationalising of NPT. Examples of the questions that we posed of the data in relation to the latter have been set out previously in our description of NPT. Data meetings were held to discuss emerging themes and to resolve ambiguities in coding, particularly in relation to NPT. The key mechanisms shaping implementation were used to structure presentation of the findings; where relevant we mapped these to NPT. In providing illustrative quotes we sought to capture the range of views expressed; where systematic differences in views relating to job roles were evident we highlight this. There were no manifest differences in participant views by divisional location.

Findings and Discussion

In this section we describe the anticipated implementation pathway and the extent to which it was travelled before considering explanations for patchy adherence to the pathway. We introduce key aspects of P2PC as we move through our analysis.

The extent of implementation

There were two ways in which relevant incidents were reported to the DAIUs. Daily, DAIUs received information concerning all DA incidents occurring over the previous 24 hours – these were risk screened by frontline officers – when the pilot was introduced this was derived from the SPECSS identification tool (Humphreys et al, 2005), a forerunner to the DASH (Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification, Assessment and Management Model (Robinson et al., 2016) now used in England and Wales and the Domestic Abuse Questionnaire used in Scotland. In addition, DAIUs receive monthly lists of perpetrators with a high Recency, Frequency, Gravity (RFG) score – an algorithm calculating risk of future perpetration by known offenders. Victims associated with these perpetrators were deemed to be at high risk of further DA but the score was recognised by Police Scotland to be an inaccurate assessment of risk as well as one lagging behind real time events. All those in this category were to be contacted by DAIU officers (responsible for investigating any crimes and in signposting support to victims). Where signed consent was provided, a notification letter would then be sent to the named GP.

In attempting to populate this pathway we drew out two key findings. First, few notification letters were sent to GPs. Whilst no figures on the total number of high risk cases during the audited period were made available, a proxy measure derived from the RFG algorithm suggests that we might have anticipated around 2,686 incidents in a 12-month period. Only 92 letters, however, were sent to GPs. Second, much of the implementation pathway was described by Police Scotland as 'untrackable' using existing data systems – in other words, it was not possible to determine what proportion of 'high risk' victims were visited or asked to consent to a GP notification letter since there was no clear denominator and since information on visits and numbers of consent sought could not be extracted from data

systems in place. Police Scotland categorically stated that their data-bases could not be searched to address these questions.

Why such low level implementation and monitoring within an organisation with a demonstrable commitment to tackling DA? Remaining alert to the fact that P2PC was implemented within a context of extensive organisational change, we found three mechanisms operating to militate against P2PC implementation. These were: the alignment of P2PC with existing practice; how the purpose and priority of P2PC for Police Scotland was signalled; and spaces for discretionary practice in frontline police work. Before discussing these, we turn to context.

The Context of Organisational Change

As noted earlier, P2PC was first developed by Strathclyde Police (Scotland's biggest Police Force and most advanced in terms of policy, practice and processes relating to gender-based violence) and introduced in 2012. In 2013, however, the world of policing beyond P2PC changed in ways that dwarfed the notification scheme. In short, during the period of interest, Scotland's police forces were merged into one. This brought significant organisational upheaval and, in relation to DA policing, new procedures, risk assessment tools, databases and significant staff relocations beyond the normal shifting deployments. More specifically, frontline officers were now being expected to use a longer and more specific assessment tool (the Domestic Abuse Questionnaire), had to input data themselves into a database instead of that being done by trained administrative staff and the database itself was changed significantly. This shifting ground meant that the intervention was not the salient 'new' poised to be embedded into existing practices but, as we shall see, a rather insignificant 'new' plunged into the even newer. Further, the changing context wrought through the establishment of Police Scotland was also one of constrained budgets as the Scottish Government responded to the wider UK government austerity programme resulting from the 2007 Global Financial Crisis.

May and Finch (2009) point to the need to surface contextual factors in order to understand the triggers for embedding new work. In describing context, they focus on 'social contexts' (p.542). Part of this 'social', we argue is to be found in the context of politics – both large and small – which, in this case, turned potentially fertile ground for P2PC into something much less hospitable. Within this context, three mechanisms intertwined to further render P2PC problematic as a means of embedding GP notification within police practice. The first of these relates to the extent to which it aligned with existing practice.

P2PC alignment with existing practice

The introduction of a new professional practice inevitably occurs within the context of pre-existing ways of working. Professional frameworks evolve over time and incorporate

incremental changes. NPT proposes that implementation of a new practice rests on those who will deliver it understanding it within existing frames of professional and personal reference. That is, for implementation to be successful it must make logical sense and cohere with current practice for those who are expected to adopt it. Within the broader construct of *coherence*, they refer to this process as *differentiation*. In order to explore this aspect of P2PC we asked participants in DAIUs to discuss the extent to which the GP notification scheme made sense to them in terms of current working and how it complemented, or clashed with, existing practice.

Before setting out their views, it is helpful to outline a key operational decision made by Police Scotland's data access specialists which shaped the work entailed by the intervention as well as defining to a large extent who the key actors within the police would be. This decision was to make it mandatory for victims to provide *signed* consent to a notification letter being sent to their GP despite this not being required to satisfy multi-agency protocols on sharing information. This requirement meant that although the trigger for an individual becoming 'eligible' for a notification letter was the domestic incident prompting a home visit by frontline officers, consent wasn't taken by these officers at the potential crime scene, but at a later date by investigation officers. This decision had two important consequences. First, getting consent became contingent on DAIU resources much more than if verbal consent had been 'allowed'. Second, frontline police officers were largely unaware of the pilot as it was deemed not to impinge on their work and they were not therefore primed to routinely ask about victims' wishes regarding notification of GPs.

What was evident across participants from DAIUs was the extent to which multi agency working was presented as commonplace and recognised as a normal part of police work. The process of making referrals was considered a key communicative act, and a routine aspect of processing DA incidents. Sending out notification letters to GPs was described, simply as "just tweaking what we already do" (FG05). In this respect, 'doing' P2PC should have required little alteration of existing work.

However, as identified, a key difference between notification of GPs and the referral of incidents to other organisations, was that consent could not be taken verbally but needed to be signed. Not only did this create operational difficulties for DAIU officers, but also meant that frontline officers, unaware of the pilot but who nonetheless sometimes asked victims about whether they wanted their GP informed, failed to take *signed* consent. Thus, even where the act of connecting up with GPs was not differentiated from that of communicating with other multi-agency partners, the procedural differentiation and its failure to be appropriately communicated brought problems to the implementation of the intervention.
As one frontline officer put it:

> I mean, being 100% honest, when I ask them, "Do you give us consent?" I don't say separately, "Are you also giving consent to the GP?" I'll be honest with you … I don't think anybody segregates the two. (WS218350).

This failure to obtain signed consent, however, meant that in the case of GP referral no notification letter would be sent, somewhat paradoxically marking P2PC as simultaneously too similar and too different from existing ways of working. Importantly, the means by which P2PC was different made it more resource intensive. After all, as one specialist officer said: 'You're not going to go out and visit someone so they can sign a form, you don't have time' (FG01). Meanwhile, the context of profound change to procedures meant that the undifferentiated elements of P2PC made it easy to ignore.

How was P2PC communicated, prioritised and monitored from above?

In this section we draw together a cluster of mini-mechanisms concerning the extent to which P2PC was signalled to key actors as important strategically and operationally. These mechanisms cut across NPT's core constructs of *coherence, cognitive participation and reflexive monitoring.*

First is the question of how P2PC was introduced to those responsible for its implementation and whether it was done in a way that gave the intervention *coherence*. Data collected across DAIUs presented a consistent account of P2PC's introduction: DAIUs received email communication from the central Domestic Abuse Coordination Unit, informing them that they were to incorporate an offer of GP referral into their daily practice. No training was offered nor written protocols provided. Some specialist officers wished to have discussed the pilot formally both within and across DAIUs: '[I]t would have been helpful if we'd all sat round a table before, and if we knew what each other was doing' (FG02). Nonetheless, the rapid mode and method by which the GP notification scheme was communicated to DAIUs was not viewed as unusual - responding quickly and without query to directives was considered a normal way of working within the context of policing. However, what was evidently lacking was any collective sense of the purpose of P2PC (a central component of *coherence*); the wider implications of this for implementation are immediately apparent when we see that specialist officers were unable to communicate its purpose to victims. As one focus group participant described it: "We've not really known how to really sell it" (FG02), whilst another commented: "I think probably, if we'd known more about it, we could probably have had loads more referrals " (FG02). Quite simply the GP notification pilot was one day absent within the materials and frames for policing DA incidents and then suddenly present without explanation.

Making sense of a new practice involves not just creating a communal understanding of its aims and objectives; tasks and responsibilities conferred on individuals must also make

sense within their existing practice. We have already discussed the issue of differentiation from other practices, but we also asked whether the intervention was valued as a means of improving practice.

Each DAIU focus group identified concrete benefits attached to the pilot, both for victims and GPs. In terms of victims, the referral letter was thought key in opening up avenues of support, acting as a catalyst for those who might otherwise find it impossible to see beyond their current abusive relationship. It was acknowledged that whilst disclosure was problematic for victims it was nonetheless desirable. Moreover, discussing their abuse with their GP was seen as an overwhelmingly healthy act, leading to appropriate treatment for existing health issues, the roots of which were likely to be in their abuse. For many participants, a letter to the GP was seen as an ice-breaker: "That bridge has been crossed for them" (FG03) one participant noted. The importance of this was articulated further:

> [GPs have] got a ten second or a couple of minutes' snapshot to see that person and not know their history, and you're not always going to be guaranteed to see that same person. So if you see something in their record that's highlighting or flagging something up, if you're a locum that's covering for somebody, then it gives you a wee bit of history that can paint a picture for how you actually deal with what's being presented to you (FG05).

Insight into a patient's wider circumstances was seen as central to what groups saw as a "good" GP, one who gives an individual the support they need. In the case of frontline officers, however, the benefits of notifying GPs of abuse were more uncertain. Some were unable to pinpoint any particular benefits. For example: 'When we're dealing wi' domestics, I struggle to see what the GP really has to do wi' that' (WS218350B).

May and Finch (2009) argue that engendering cognitive participation is necessary to embed practice. As we have intimated, the process of securing engagement of key actors was taken rather lightly in relation to P2PC – in fact it wasn't viewed as work in the ways described by May and Finch. Implementation, in other words, wasn't viewed as a process but as a command and, as such, getting implementing police officers on board wasn't viewed as requiring engagement at all. Initiation was a single email to DAIUs, no formal documentation existed, staff weren't canvassed for their views and no communication was provided to the wider group of police officers who attend DA incidents. So the question of why and how key actors become engaged with a new practice is answered quite simply: the work of communicating P2PC was on a command and control basis with assumptions of compliance rather than engagement; it was communicated on the narrowest 'need to know' basis and did not itself engage with building support from those expected to implement. This issue also chimes with the perspective of organisational justice (Greenberg, 1987) where employees' perceptions of a fair system of working and, by implication, trust in their organisation, can be damaged when communications between layers of management are

viewed as one-way (as in a command and control system) rather than reciprocal (Saunders & Thornhill, 2003).

Of further relevance to the embedding of P2PC is where the boundaries of the system are drawn. As an effort to open up a communication route between police and GPs, P2PC offered only a weak link that did little to encourage what May and Finch call *relational integration*. As we shall see when we turn to the question of strategic commitment to learning, that link was not reciprocated and nor did it help to enlighten police about the largely unknown practices of GPs. In this respect, the intervention exemplifies the lack of connection between the different planets of police and primary care that parallels the different planets of DA, child protection and child contact identified by Hester (2011). She suggests that professionals working in particular areas of interest operate with everyday assumptions that do not mesh with those of professionals working in connected but different areas of interest. For P2PC, therefore, we have a literal representation of the phenomenon described by Hester, in that practices are rendered invisible 'from a different professional perspective' (Hester, 2011: p.839). Police officers had no sense of what might happen on the back of a received notification letter. One elaborated:

> I was never very sure where the GP thing actually sat. And if we sent that letter in, actually, what difference it was going to make on the whole. But I wasn't really entirely sure where it all kind of sat with it, whether they would then contact them and say, "are you alright?" Or whether the next time they went in, that they'd be made aware of that and they would maybe speak to them about it.' (PO5).

Finally, an important organisational signal of the priority of a particular type of work is that its implementation will be monitored to learn how best to proceed. In NPT terms this is referred to as *reflexive monitoring*. Again, the pressures of rapid organisational change significantly constrained the extent to which the DACU could engage in organisational learning, although paradoxically, the unit played a significant role in supporting the external evaluation of P2PC.

We found that data were not routinely interrogated and acted upon in relation to numbers of notification letters being sent; nor were the views of key actors in Police Scotland concerning P2PC sought from a strategic perspective. Whilst data were collected routinely, in so far as all letters sent to GPs were expected to be logged, as discussed earlier, there was no search facility to allow ready calculation of total numbers of letters. Databases needed to be searched per incident to provide this information. Thus, requests for information relating to GP notification letters required additional work on the part of DAIUs. Furthermore, data completeness was potentially problematic; as one division reported:

> 'If you remember to put it on the spreadsheet then good, but sometimes, if you've got a mountain of stuff to get through, it could get missed.' (FG04).

One division expressed the view that the process for recording and monitoring had not been sufficiently standardised: '[E]very division's sort of left to their own devices' (FG04). In addition, data did not appear to be routinely sent to, and reviewed by, the DACU; indeed, in one division, the request for data on notification letters was acted upon not as a routine data request but as a prompt to do something about implementation:

> 'Our Sergeant … s/he was starting to ask us when s/he was allocating a domestic to us - 'consider GP referral'. That's the first time that it's started to be kinda mentioned to us to do it. Following the coordination unit, I'm guessing, looking at our stats' (FG01).

DAIU participants were asked whether their views on the pilot had been sought either within their own division or more centrally. No division reported that they had been asked for their perspective. Interestingly, there was little sense from participants that this lack of consultation on the experience of implementation was unusual; the expectation to do new things without explicit reflection was considered 'normal'. One respondent said, 'I think it's just a case of, it's a force procedure and you just need to follow the procedure and do what you can do, when you can do it' (FG04). Again, we see the potentially uneasy tension between command and control and normalised discretion; we also see an acknowledgment of the lack of evaluation culture that has been recognised as a feature of police work (Neyroud & Weisburd, 2014).

In relation to data or information being fed back to DAIUs there was, again, little evidence of information flow. DAIUs stated that they had neither received (nor sought) feedback from frontline officers or other colleagues involved in obtaining written consent from victims. Likewise, there was no indication across investigation units that they received feedback about the pilot from above. Finally, interviewees discussed the lack of feedback received from those in primary care (as discussed earlier) and also from women themselves:

> 'No victim's ever come back and said 'oh I went to my doctor's the next time, it was great because they knew about this and I didn't have to go through it'' (FG02).

For some participants, the lack of confirmation on how information was being used was unproblematic. For others, the overall coherence of the pilot was blurred by an absence of information about its utility and benefits. Of particular concern was whether GP referral letters themselves fulfilled their perceived remit of opening up routes into primary care support for victims - that is, whether the letters were an effective means of inter-agency working, opening an otherwise blocked channel of communication between the police and the GPs; one captured this as follows: ''we get absolutely nothing back …they could be getting filed in the bucket' (FG02).

What evidence was there that key actors were reflecting about the success or otherwise of P2PC or for learning being shared within and across DAIUs? These questions appear

pertinent to the assessment of May and Finch's concepts of *communal* and *individual appraisal*. Consistent with the discussion above, no examples were provided of formal appraisal of the pilot either within or between DAIUs. Asked about the communication between DAIUs, the response shared across units was 'we don't really have any contact with other [units]' (FG02). Informally, however, *communal* and/or *individual appraisal* was evident in the judgements made about the pilot. These included reflections about how verbal consent would increase the number of victims being offered the opportunity for a notification letter to be sent and views on the need for better communication flow between police and primary care (specifically GPs). Nonetheless, given the lack of systematisation of feedback loops and focus on collective learning, it is not surprising that there were no examples of changes to practice as a result of formative learning from the pilot. That such lack of attention to learning was found to be commonplace is again symptomatic of the wider identified problem within the policing literature concerning a gulf between scientific and police concerns. As Willis and Mastrofski have argued: 'science as a harbinger of change …. [is] currently a relatively weak player' (2014: p.322).

Discretionary Spaces

As well as a concern for how work is introduced and the priority that it is afforded, NPT is concerned with how new work gets done. This it calls *collective action*. It incorporates how it is operationalised by key actors (*interactional integration*), and how it changes the ways these actors see the actions of others around them (*relational integration*. In this section we discuss P2PC in relation to these questions (*contextual integration* – the way in which the new sits within existing structures and procedures and *skill-set workability* – how new tasks are divided between professionals - have already been discussed in relation to the alignment of P2PC with other elements of police work). In particular, we report on the extent to which the intervention and wider DA work allow significant discretionary spaces for practitioners.

An emerging theme of significant relevance to how P2PC was implemented (or not) was the visibility of discretion particularly in the absence of more strategic, directional work as previously described. In particular, discretion was practiced in relation to how risk was operationalised and to whether/how consent for a GP notification letter was sought. Specialist officers talked extensively of the discretion they exercised in daily practice, in particular who to visit in person following a DA incident. They described over-riding RFG calculations that seemed to have poor predictive accuracy. In reality, deciding who was 'high risk' was informed by more nuanced means, including professional experience and communal knowledge about specific individuals in addition to risk assessments from attending officers. The following illustrates this discretion in action as a specialist officer describes how alarm bells are rung by the seemingly innocuous:

> ‘Sometimes you will get a call and it’s quite trivial…and you think what has caused that person on that day to phone the police because it’s something that normally you wouldn’t phone the police about. But obviously something’s happened that’s made them pick up the phone and phone the police. And you just think…That’s interesting”…”There must be more to this’ (FG04)

In some DAIUs in particular, however, resources dictated that few potentially high risk victims could be visited for their signed consent. Discretion in practice was evident too in the way that asking for consent was prioritised during visits. For some specialist officers, the process of asking victims for consent for notification was differentially viewed as mandatory -‘a bland statement’ (FG03) to be read out to victims - or discretionary-‘it’s a judgement call depending on the reaction you get from [victims]’ (FG02). Not surprisingly then, there were opposing views of how the question was received by victims. One reported: ‘I cannae remember if somebody has said “yes”. That’s how minority it is’ whilst another countered: ‘I don’t think anybody’s come, really come up – from my own personal experience – and sort of been like, “No way!”’. These variations in response are consistent with variations that have been found in the application of DA risk assessment tools by police forces across the UK and indicate the need for caution in over reliance on standardised tools as a means of delivering consistent (and consistently appropriate) practice (Myhill & Johnson, 2016; Robinson et al., 2016; Almond et al., 2016). As Trujillo and Ross have argued (2008), researchers need to pay closer attention to the ‘situational dynamics’ (p.454) of the risk assessment process.

The importance of understanding discretion and how it plays into practice is evident when we see data that demonstrates opposing views of the potential utility of P2PC. This ranged from a view that it was important work with potentially significant impacts for women to a rather more cynical and less common view that sending information to GPs was a form of ‘arse-covering’. We juxtapose these two views below:

> (1) ‘We’re telling them, “Listen, we’re all working together for you. The fact that I’m telling your GP might mean that you don’t have that initial embarrassment factor having tae tell him “I’m the victim o’ DA”. I’m doing that for you and you can go in there wi’ your head held high because the GP will know it’s not your fault.” (PO2).

> (2) ‘ Say like a victim had been murdered, and one of the things they [the police] could maybe do is look and say ‘Right, a GP referral letter got sent on that date…I think […] with DA… what they do like to do is just cover your arse, I think … it’s just, ‘well, we’ve done that’. So that if anything did happen…we’ve had that in place (FG03).

Discretion allows flexibility and user-centred service provision as well as poor practice to flourish and helps us to understand how, what May and Finch describe as 'goal orientation' (2009; p.544) can be characterised by 'resistance, subversion or reinvention, as well as affirmation and compliance'. Without significant strategic work to develop and disseminate the purpose and priority of P2PC as a tool within the multi-agency repertoire, discretion allowed the intervention to hover in sight of practice for some specialist officers without bedding in. Discretionary and actual practice of police officers constitute the 'craft' that Willis and Mastrofski argue is both a 'compelling topic for scientific inquiry' (2014: p.324) and a knowledge base that 'science has left largely unexamined' (2014: p.325).

Conclusion: Illuminating the (non) implementation of P2PC through NPT

Drawing together the mechanisms above, we conclude that P2PC was rendered invisible as an intervention. It was dwarfed by its organisational context, made institutionally hard to read by the lack of formal protocols and procedures in its introduction, and given restricted view in terms of who within the police saw it. Indeed, any opportunities that did arise to shine a light on P2PC as a worthwhile intervention were ultimately and fatally compromised by a failure to instigate methods and systems of monitoring and organisational learning.

There were three key mechanisms that, amidst enormous contextual change, led to minimal implementation of P2PC and these are usefully illuminated through the use of NPT: poor operational alignment of the intervention with existing practice; sub-optimal communication of P2PC and its purpose and priority within broader Police Scotland strategies for multi-agency communication; and, a lack of attention to discretionary spaces around implementation. It also provided some clues around the circumstances where it did lead to practice that was closer to the planned approach. These included cases where the *spirit* of the intervention (Rod et al; 2014) was intuited and supported by some specialist officers and where the resources were in place to allow an operational requirement of the intervention – that is, acquiring signed consent – to be met.

In particular, NPT helped to illuminate and explain two paradoxes exemplified by P2PC. The first relates to the mode of implementation whereby a command and control culture simultaneously engendered an unquestioning approach to new directives *and* a willingness to disregard these if they are not followed up by subsequent management communications. The second relates to the readiness of Police Scotland to be involved and commit significant staff resources to an external evaluation whilst simultaneously demonstrating a lack of interest in the ongoing internal evaluation of day-to-day and longer term working practices.

There were lessons too concerning the application of NPT. What NPT does not do so effectively, in our view, is *foreground* the following components of implementation. First, that the absolute centrality of context needs to be related to each of its constructs: organisational, financial and political elements of context imbue and structure each element of the process of implementation and need to be at the heart of a consideration of if and

how each mechanism generates action. Second, whilst not in the least incompatible with NPT, we argue that spaces for discretionary practice (made by organisations and enacted by workers) should be more explicitly signalled and investigated by NPT researchers.

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